DEPARTMENT OF HEALTH AND HUMAN SERVICES
RURAL MEDICAL ACCESS PROGRAM (RMAP) APPLICATION–2011
Due Friday, April 29, 2011

Send applications to: Charles Dwyer, Director
Maine CDC Office of Rural Health and Primary Care, #11 SHS,
286 Water Street, 6th Floor, Augusta, Maine 04333-0011
Tel: 207-287-5524 Fax: 207-287-5431

PHYSICIAN NAME _____

PRACTICE NAME _____

ADDRESS _____

TOWN_____ZIP _____

PHONE_____

EMAIL_____

MAINE PHYSICIAN LICENSE # _____

MAINECARE PROVIDER # _____
Include all MaineCare Provider #s under which you bill for prenatal care in the practice listed on this application. (Failure to provide the MaineCare number will affect the application process.)

If you do not perform deliveries yourself, to whom do you refer patients?
NAME(s)_____

ADDRESS(es)_____

Attach a copy of your agreement(s) with physician(s).

PRACTICE IS LOCATED:
____ in a designated Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA).

____ outside a designated area (Review Designations at: http://hpsafind.hrsa.gov/)
Provide the total number of Non-MaineCare visits _____ and list the towns in designated areas where the Non-MaineCare patients reside.

_____

_____

_____

_____

_____

PRENATAL AND/OR OBSTETRICAL COVERAGE FOR (Please Check One):
___ the entire period (1-1-10 thru 12-31-10)

___ a portion of the period, specify _____
If you were covered for a portion of the period, coverage **must** have begun on or before July 1, 2010 and remained in effect until December 31, 2010 to be considered.

Total # of patient visits: _____

Total # of MaineCare visits: _____

Total # of prenatal visits: _____

Total # of MaineCare prenatal visits: _____

Total # of deliveries performed: _____

Total # of MaineCare deliveries performed: _____

Hours per week prenatal/obstetrical care provided:_____

We continually evaluate the Rural Medical Access Program. Please assist us by completing the following questions. Thank you.

1. Does participation in the RMAP make a difference in whether you serve this area/population?

2. If the assistance stopped, would you continue to provide prenatal/obstetrical care for this area/population?

3. Your comments about the program are welcome.

* *

INSURANCE COMPANY _____ POLICY # _____

PAYER OF PREMIUM: Self ____
Other: Name _____ Phone _____Fax_____

Address _____

CERTIFICATION: I certify that the above information is correct to the best of my knowledge.

Signature _____ Date _____

RMAPAPPL 11. Revised 02/25/11
FOR OFFICE USE ONLY--RECVD_____; NOTIFIED OF RECEIPT_____; NOTIFIED OF REVIEW_____